Statement of Joel White, Executive Director
Coalition for Affordable Health Coverage
to the
Committee on Ways and Means
Subcommittee on Health

Hearing on Health Care Industry Consolidation
September 9, 2011

Introduction

Chairman Herger, Ranking Member Stark and Members of the Subcommittee, thank you for holding this hearing on health industry consolidation.

The Coalition for Affordable Health Coverage (CAHC) is a broad-based alliance with a singular focus: bringing down the cost of health care for all Americans. Our membership reflects a broad range of interests—organizations representing small and large employers, manufacturers, retailers, insurers, brokers and agents, physician organizations and individual consumers.

We are concerned that health coverage has become much less affordable over the last decade—a trend that continues despite the passage of major reform legislation. Runaway medical spending is adversely affecting a range of national indicators, from economic competitiveness, to public sector fiscal balances, to national employment levels, to household living standards. Indeed, correcting what many see as symptoms of national decline requires looking no further than our broken health system.

Consolidation is leading to highly concentrated markets across the country and in your districts, which, in turn, are dramatically driving up the price of health services and the overall cost of care. This is translating into inflated government spending, higher premiums, and inefficient cost shifting. These factors are creating strong head winds in our labor markets, making retaining and hiring workers more difficult and creating a drag on our economy and household finances.

Market Concentration Creates An Unbalanced Playing Field

Studies of price variation show that higher prices reflect provider market power in addition to the quality and intensity of care, population differences, and the prevalence of Medicare and Medicaid patients. Concentrated markets tend to have higher prices and greater price variation. [i, ii]

Horizontal Consolidation

Market consolidation takes a variety of forms. The classic example is the horizontal consolidation of hospitals within markets through merger and acquisition. Although these kinds of combinations are the most subject to regulatory scrutiny, antitrust authorities have permitted large numbers to go forward over the years. California alone saw more than 900 mergers and acquisitions during the 1990s.

Currently, the Department of Justice and the Federal Trade Commission use the Herfindahl-Hirschman Index (HHI) to classify the degree of concentration in markets: unconcentrated (HHI below 1,500); moderately concentrated (HHI between 1,500 and 2,500); and highly concentrated (HHI above 2,500). Mergers resulting in unconcentrated markets are

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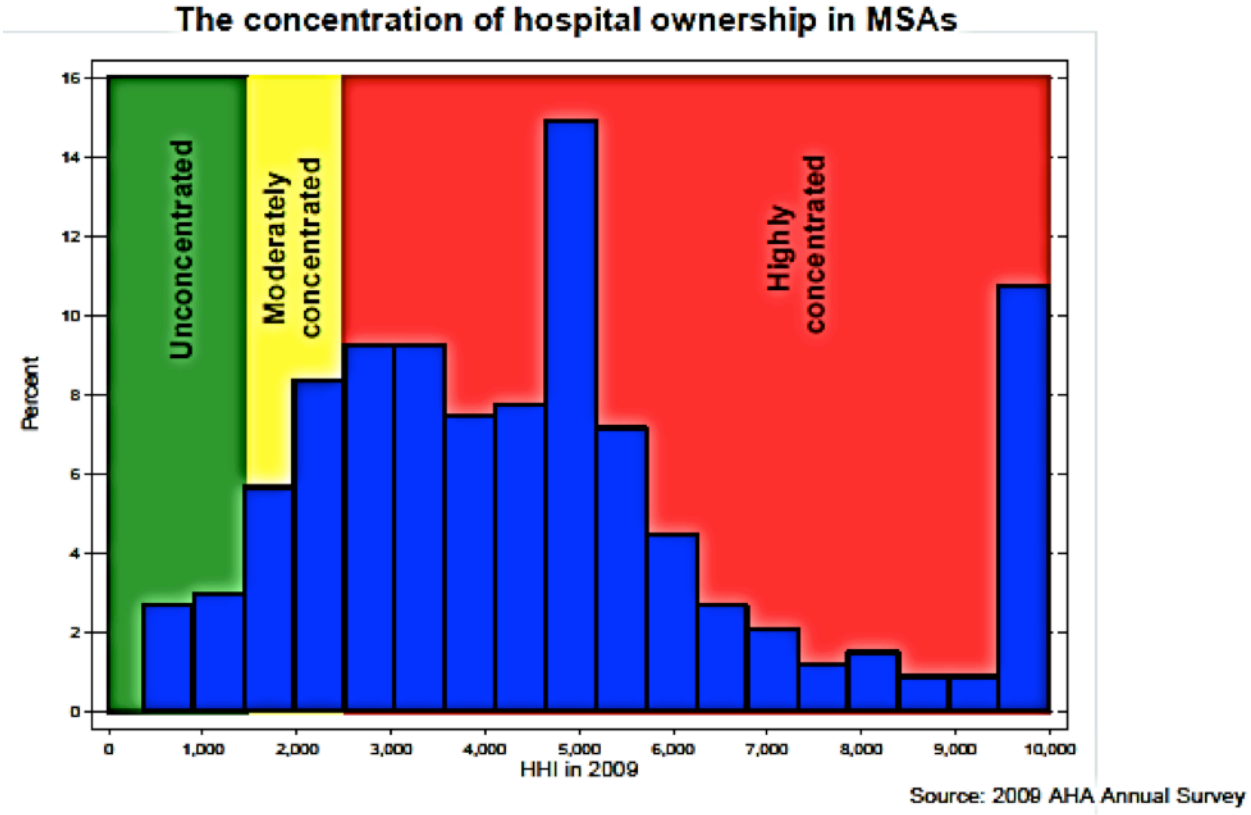
unlikely to have adverse competitive effects and ordinarily require no further analysis from the FTC or DOJ. Mergers resulting in moderately or highly concentrated markets potentially raise significant competitive concerns and often warrant agency scrutiny.

By 2003 almost 90 percent of Americans in metropolitan areas had "highly concentrated" hospital markets, according federal antitrust standards.[iii] Ten percent of metropolitan statistical areas have only one hospital system—and therefore no realistic prospect of price-competition. The American Hospital Association provides data on the concentration of hospital ownership in MSAs, which is represented below.



Over the 3 years from 2006 to 2009 most MSAs saw modest changes in the HHI, with the average HHI across MSAs increased by 61 points. 30 MSAs saw increases in the HHI of more than 500 points and large increases in the HHI outnumbered large decreases by a 2-to-1 margin.

Hospital mergers and acquisitions have had significant price effects. Estimates of price increases range from four percent to 53 percent depending on the samples and methodologies used. A widely accepted rule of thumb is that prices increase 40 percent when the merging facilities are closely located.[iv]

Complicating the measurement of price effects is the fact that, when merged entities raise prices, non-merged competitors tend to follow suit. In addition, consolidation across regional markets can increase the price-setting power of hospital systems and physician groups indirectly.

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For example, by giving health plans the choice of contracting with all or none of their facilities in multiple markets, hospital systems with a "must-have" facility in one market can drive up prices for their more ordinary facilities elsewhere.[v]

Vertical Integration

A more recent trend in consolidation involves the vertical integration of hospitals and medical practices. Hospitals now employ one in six doctors nationally. The Medical Group Management Association reports a nearly 75 percent increase in the number of doctors employed by hospitals since 2000. Accenture has estimated that only one in three doctors are likely to remain independent by 2013.[vi] Joining with hospitals can increase physician bargaining clout with insurers while giving hospitals a guaranteed flow of referrals.[vii]

Consolidation has also allowed single-specialty and other clinically integrated medical groups to gain "must have" status. Writing in Health Affairs, Robert Berenson et al. document how clinically integrated physician groups in California have pushed up prices for health maintenance organizations to the extent that, in many cases, HMOs are less economically viable than fee-for-service insurance products.[viii]

Some providers have also used their market power to negotiate product participation agreements, such as "anti-steering," "guaranteed inclusion" and "product participation parity" clauses, which limit insurers' ability to develop new products and promote value-based consumer choice. These practices may be anti-competitive, but certainly drive up health costs.

Insurance Markets

Finally, there is some evidence that price discrimination—a feature of concentrated provider markets—increases concentration among insurers. The American Medical Association reports that in 60 percent of metropolitan statistical areas, the two largest insurers combined have a 70 percent or higher market share. AMA estimates that 99 percent of health insurance markets are highly concentrated.[ix] Yet the prices insurers and providers negotiate tend to reflect their relative market power, with the result that insurers with a large presence in a region are able to obtain lower prices.

Some insurers have sought to cement their market advantage through parity agreements (such as "most favored nation" clauses) that provide an insurer with substantial market share to enter into an exclusive contractual arrangement to get the best discounts offered by a provider in a certain geographic area. This allows the insurer to maintain a dominant market position. Typically the contract language will state that the health insurer or payer will receive the lowest price that has been given to any other health insurer in the market. These types of contracts make it difficult for any insurer other than a dominant carrier to offer competing coverage as an affordable option to consumers.

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Implications

The implications of horizontal, vertical and anti-competitive contract arrangements means markets are not as free as some would argue or hope. It is certainly true that markets are becoming more concentrated, and that this concentration is creating un-level playing fields that result in prices that reflect relative market power, and not input costs. When these market situations result in monopolies, there is a significant loss to consumer welfare in the form of higher premiums and less affordable medical care and insurance coverage.

PPACA Does Not Address Core Concentration Issues, and May Make Matters Worse

Because health markets are becoming increasingly concentrated, consumers have fewer affordable choices. PPACA shifts many of the existing costs of consolidation onto taxpayers through new subsidy mechanisms, but PPACA does not address the underlying concentration problems, and may, in fact, make matters worse.

For example, the Medicare Shared Savings Program that seeks to establish Accountable Care Organizations (ACOs) has the potential to lower costs while improving quality. Done well, the program will support higher value in the health system by rewarding superior and more efficient care. Done poorly, however, ACOs hold the potential to further concentrate provider markets and create barriers to competition that will drive up costs for consumers and patients. CAHC is particularly concerned about the potential spill-over impact of the regulations on commercial markets.

The record suggests that unregulated clinical integration envisioned under the ACO model will lead to the greater vertical consolidation of provider markets, which in turn will fuel cost growth, making medical care less affordable. Any integration and concentration that may result from the implementation of ACOs should be closely supervised by the FTC, Justice Department and state regulatory authorities to ensure that clinical integration results in proportional savings to private payers. We encourage the Subcommittee to maintain vigilance over the program's implementation.

Lastly, it is unclear what impact health benefit exchanges may have on market concentration for insurers. Again, done well, exchanges hold promise to expand competition in the insurance market and provide more options for consumers. Exchanges that limit choices through mechanisms such as selective contracting, will not promote expansive choice among competing health plans. Benefit exchanges will do nothing to address provider concentration issues.

Current Enforcement Mechanisms Are Not Adequate

While the FTC and some courts have concluded that market power can be problematic, recent agency activity shows a lack of willingness from enforcers to break up existing merged entities, even in highly concentrated markets. Christine Varney, head of the Antitrust Division at the Department of Justice, noted in a speech in May of 2010 her commitment to maintain open

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and competitive markets through enforcement actions. While laudable, the recent consolidation in local markets may point to a lack of resources at the Department to systemically review local market concentration.

Little Transparency

In normal markets, sellers compete on of price and quality, which in turn stimulates innovation. The driving force in this process is price-sensitivity—consumers demanding more for less. In the health sector, these price signals are weak or missing altogether. One oft-cited reason for this demand-side disconnect is the prevalence of third-party payment systems, which shield patients from the financial consequences of choosing high-cost providers. Another is that employers, who sponsor the preponderance of private plans, have few incentives to push back on costs: for the most part, they have been able to pass on rising premiums in the form of lower wage increases.

In addition, fee-for-service (FFS) payment systems, which pay sellers of medical services more for doing more, create powerful incentives not to economize. There is also evidence that excessive market power undercuts the business case for reducing costs.

Even in the most competitive markets, the lack of usable information on cost and quality prevents consumers from directing their business to efficient providers.[x] Hospitals have 20,000-30,000 items in their "charge masters," which consist of list prices charged mainly to those patients with the least market power.[xi] Health plans generally are able to negotiate much lower rates. While anti-trust guidelines permit health plans to provide comparative data to their members, they prohibit them from publicly posting actual prices, in the belief that doing so would discourage providers from giving secret discounts, thus driving up average prices.[xii] In other instances, hospitals have insisted on "gag-clauses" in their contracts that prohibit health plans from disclosing hospital cost and quality information to their members.[xiii] Removing barriers to transparency will be essential to unleashing the power of consumerism.

Congress Must Take Steps to Address Concentration Issues

Over the past several decades, the argument over free versus managed or government run markets has emerged as a flash point in the dialogue over how to best lower health costs. This misses the point. So long as markets remain highly concentrated, no amount of market reform is likely to succeed. because price fixing by oligopolies or monopolies is just as inefficient as price setting by government regulators.

Congress can take several steps to begin to address health industry consolidation, market concentration and barriers for consumers to obtain information on cost and quality.

a. **Require CMS to measure local market concentration.** CMS could use its extensive data on providers and billing to develop local measures of provider concentration. Methods similar to those used by MedPAC could lead to measures of propensity to shift costs, by local market.

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b. **Enforce existing antitrust law.** Congress could require the more rigorous enforcement of existing antitrust standards. FTC classifies markets with a Herfindahl-Hirschman Index score above 2,500 (e.g., four firms with equal market shares) as "uncompetitive." A rule of thumb is that each 160-point increase in the HHI corresponds to a one percent price increase. Rigorous enforcement could prevent future such mergers. Yet FTC has permitted the formation of hundreds of such oligopolies in recent decades—with the result that high degrees of concentration are a *fait accompli* in most markets. One option would be to de-concentrate markets through the retroactive enforcement of existing standards.

c. **Modify antitrust law.** An alternative is to expand the remedies available under antitrust law. One possibility would be to permit the supervised collusion of payers (insurers, employers, consumer organizations) in the most concentrated markets. Writing in the current issue of Health Affairs, Glenn Melnick and colleagues show that greater consolidation on the payer side can constrain the power of monopoly and oligopoly. Finally, FTC prohibits insurers from publicizing the price they pay to specific providers, on the theory that, in today's oligopolistic markets, providers would stop offering secret discounts, thus causing average prices to rise. If pursued in concert with other policies that inhibit cost shifting, eliminating such restrictions could facilitate price transparency and consumer choice.

d. **Prohibit practices conducive to price fixing.** As noted above, providers, in some cases with the cooperation of insurers, have used their market power to negotiate product participation agreements, such as "anti-steering," "guaranteed inclusion" and "product participation parity" clauses, which limit insurers' ability to develop new products and promote value-based consumer choice. For example, "gag clauses" prevent insurers from providing price information even to their own customers (e.g., "In no event will [hospital] providers be singled out in a tier, limited network, or other product…") "Most favored nation" clauses prohibit providers from charging rival insurance plans less for their services. Concentration across markets can effectively circumvent antitrust restrictions. For example, by giving health plans the choice of contracting with all or none of their facilities in multiple markets, hospital systems with a "must-have" facility in one market can drive up prices for their more ordinary facilities elsewhere. One recent FTC enforcement action required each facility in merged hospital systems to negotiate prices independently. Congress could ban these practices as detrimental to consumer welfare.

Conclusion

Given the degree of concentration in local markets, necessary and appropriate efforts to limit Medicare and Medicaid reimbursement growth will simply result in higher costs – via cost-shifting - for the dwindling share of privately insured workers and their dependents, whose rising premiums, like payroll taxes, are deducted from cash wages. The experience of high-productivity providers such as Intermountain Healthcare, Mayo Clinic and Geisinger underscores

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that enormous productivity gains—exceeding 30 percent—are well within the reach of American medicine.

Congress ought to take steps to rebalance markets and level the playing field. Doing so should create necessary incentives to lower health costs, which in turn will help improve labor markets and improve our Nation's balance sheet.

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